AMENDED IN ASSEMBLY AUGUST 28, 2000

AMENDED IN ASSEMBLY AUGUST 25, 2000

AMENDED IN ASSEMBLY JUNE 15, 2000

AMENDED IN SENATE MAY 1, 2000

SENATE BILL No. 2094

Introduced by Committee on Insurance (Senators Speier (Chair), Escutia, Figueroa, Hughes, Johnson, Johnston, Leslie, Lewis, Schiff, and Sher)

February 25, 2000

An act to amend Sections 56.05, 56.10, 56.30, and 56.101 of the Civil Code, to amend Sections 1347.15, 1363.5, 1364.5, 1367.01, 1367.51, 1368, 1368.04, 1370.4, 1375.4, 1386, and 1395.6 of, to amend and renumber Section 13933 of, and to repeal Section 1367.5 of, the Health and Safety Code, to amend Sections 10123.135 and 10145.3 of the Insurance Code, and to amend Section 25002 of the Welfare and Institutions Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 2094, as amended, Committee on Insurance. Health care.

Existing law provides for the regulation and licensing of health care service plans by the Department of Managed Care, effective no later than July 1, 2000, or earlier pursuant to an Executive order of the Governor. Existing law provides for the regulation and licensing of disability insurers by the Department of Insurance.

The Confidentiality of Medical Information Act limits the disclosure of medical information by a provider of health care, a health care service plan, or a contractor relative to a patient, as specified.

This bill would make technical changes to various provisions of that act and other health care-related provisions by correcting erroneous section references and making other related conforming and clarifying changes.

This bill would incorporate additional changes to Section 56.10 of the Civil Code proposed by AB 2414 and SB 1903, to be operative if this bill and one or more of the other bills are enacted and become effective on or before January 1, 2001, and this bill is enacted last.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 56.05 of the Civil Code is amended to read:

56.05. For purposes of this part:

(a) ''Authorization'' means permission granted in accordance with Section 56.11 or 56.21 for the disclosure of medical information.

(b) ''Authorized recipient'' means any person who is authorized to receive medical information pursuant to Section 56.10 or 56.20.

(c) ''Contractor'' means any person or entity that is a medical group, independent practice association, pharmaceutical benefits manager, or a medical service organization and is not a health care service plan or provider of health care. ''Contractor'' shall not include insurance institutions as defined in subdivision (k) of Section 791.02 of the Insurance Code or pharmaceutical benefits managers licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(d) ''Health care service plan'' means any entity regulated pursuant to the Knox-Keene Health Care

Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(e) ''Licensed health care professional'' means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act or the Chiropractic Initiative Act, or Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

(f) ''Medical information'' means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, or contractor regarding a patient's medical history, mental or physical condition, or treatment. ''Individually identifiable'' means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

(g) ''Patient'' means any natural person, whether or not still living, who received health care services from a provider of health care and to whom medical information pertains.

(h) ''Provider of health care'' means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code; any person licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act; any person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code; any clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. ''Provider of health care'' shall not include insurance institutions as defined in subdivision (k) of Section 791.02 of the Insurance Code.

SEC. 2. Section 56.10 of the Civil Code is amended to read:

56.10. (a) No provider of health care, health care service plan, or contractor shall disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization, except as provided in subdivision (b) or (c).

(b) A provider of health care, a health care service plan, or a contractor shall disclose medical information if the disclosure is compelled by any of the following:

(1) By a court pursuant to an order of that court.

(2) By a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority.

(3) By a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum, notice to appear served pursuant to Section 1987 of the Code of Civil Procedure, or any provision authorizing discovery in a proceeding before a court or administrative agency.

(4) By a board, commission, or administrative agency pursuant to an investigative subpoena issued under Article 2 (commencing with Section 11180) of Chapter 2 of Part 1 of Division 3 of Title 2 of the Government Code.

(5) By an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum issued under Section 1282.6 of the Code of Civil Procedure, or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.

(6) By a search warrant lawfully issued to a governmental law enforcement agency.

(7) By the patient or the patient's representative pursuant to Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(8) When otherwise specifically required by law.

(c) A provider of health care, or a health care service plan may disclose medical information as follows:

(1) The information may be disclosed to providers of health care, health care service plans, contractors, or

other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation, the communication of patient information by radio transmission or other means between emergency medical personnel at the scene of an emergency, or in an emergency medical transport vehicle, and emergency medical personnel at a health facility licensed pursuant to Chapter 2 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

(2) The information may be disclosed to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, contractor, or any other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made. If (A) the patient is, by reason of a comatose or other disabling medical condition, unable to consent to the disclosure of medical information and (B) no other arrangements have been made to pay for the health care services being rendered to the patient, the information may be disclosed to a governmental authority to the extent necessary to determine the patient's eligibility for, and to obtain, payment under a governmental program for health care services provided to the patient. The information may also be disclosed to another provider of health care or health care service plan as necessary to assist the other provider or health care service plan in obtaining payment for health care services rendered by that provider of health care or health care service plan to the patient.

(3) The information may be disclosed to any person or entity that provides billing, claims management, medical data processing, or other administrative services for providers of health care or health care service plans or for any of the persons or entities specified in paragraph (2). However, no information so disclosed shall be further disclosed by the recipient in any way that would be violative of this part.

(4) The information may be disclosed to organized committees and agents of professional societies or of medical staffs of licensed hospitals, licensed health care service plans, professional standards review organizations, independent medical review organizations and their selected reviewers, utilization and quality control peer review organizations as established by Congress in Public Law 97-248 in 1982, contractors, or persons or organizations insuring, responsible for, or defending professional liability that a provider may incur, if the committees, agents, health care service plans, organizations, reviewers, contractors, or persons are engaged in reviewing the competence or qualifications of health care professionals or in reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.

(5) The information in the possession of any provider of health care or health care service plan may be reviewed by any private or public body responsible for licensing or accrediting the provider of health care or health care service plan. However, no patient identifying medical information may be removed from the premises except as expressly permitted or required elsewhere by law, nor shall that information be further disclosed by the recipient in any way that would violate this part.

(6) The information may be disclosed to the county coroner in the course of an investigation by the coroner's office.

(7) The information may be disclosed to public agencies, clinical investigators, including investigators conducting epidemiologic studies, health care research organizations, and accredited public or private nonprofit educational or health care institutions for bona fide research purposes. However, no information so disclosed shall be further disclosed by the recipient in any way that would disclose the identity of any patient or be violative of this part.

(8) A provider of health care or health care service plan that has created medical information as a result of employment-related health care services to an employee

conducted at the specific prior written request and expense of the employer may disclose to the employee's employer that part of the information that:

(A) Is relevant in a law suit, arbitration, grievance, or other claim or challenge to which the employer and the employee are parties and in which the patient has placed in issue his or her medical history, mental or physical condition, or treatment, provided that information may only be used or disclosed in connection with that proceeding.

(B) Describes functional limitations of the patient that may entitle the patient to leave from work for medical reasons or limit the patient's fitness to perform his or her present employment, provided that no statement of medical cause is included in the information disclosed.

(9) Unless the provider of health care or health care service plan is notified in writing of an agreement by the sponsor, insurer, or administrator to the contrary, the information may be disclosed to a sponsor, insurer, or administrator of a group or individual insured or uninsured plan or policy that the patient seeks coverage by or benefits from, if the information was created by the provider of health care or health care service plan as the result of services conducted at the specific prior written request and expense of the sponsor, insurer, or administrator for the purpose of evaluating the application for coverage or benefits.

(10) The information may be disclosed to a health care service plan by providers of health care that contract with the health care service plan and may be transferred among providers of health care that contract with the health care service plan, for the purpose of administering the health care service plan. Medical information may not otherwise be disclosed by a health care service plan except in accordance with the provisions of this part.

(11) Nothing in this part shall prevent the disclosure by a provider of health care or a health care service plan to an insurance institution, agent, or support organization, subject to Article 6.6 (commencing with Section 791) of Part 2 of Division 1 of the Insurance Code,

of medical information if the insurance institution, agent, or support organization has complied with all requirements for obtaining the information pursuant to Article 6.6 (commencing with Section 791) of Part 2 of Division 1 of the Insurance Code.

(12) The information relevant to the patient's condition and care and treatment provided may be disclosed to a probate court investigator engaged in determining the need for an initial conservatorship or continuation of an existent conservatorship, if the patient is unable to give informed consent, or to a probate court investigator, probation officer, or domestic relations investigator engaged in determining the need for an initial guardianship or continuation of an existent guardianship.

(13) The information may be disclosed to an organ procurement organization or a tissue bank processing the tissue of a decedent for transplantation into the body of another person, but only with respect to the donating decedent, for the purpose of aiding the transplant. For the purpose of this paragraph, the terms ''tissue bank'' and ''tissue'' have the same meaning as defined in Section 1635 of the Health and Safety Code.

(14) The information may be disclosed when the disclosure is otherwise specifically authorized by law, such as the voluntary reporting, either directly or indirectly, to the federal Food and Drug Administration of adverse events related to drug products or medical device problems.

(15) Basic information including the patient's name, city of residence, age, sex, and general condition may be disclosed to a state or federally recognized disaster relief organization for the purpose of responding to disaster welfare inquiries.

(16) The information may be disclosed to a third party for purposes of encoding, encrypting, or otherwise anonymizing data. However, no information so disclosed shall be further disclosed by the recipient in any way that would be violative of this part, including the unauthorized manipulation of coded or encrypted

medical information that reveals individually identifiable medical information.

(17) For purposes of chronic disease management programs, information may be disclosed to any entity contracting with a health care service plan to monitor or administer care of enrollees for a covered benefit, provided that the disease management services and care are authorized by a treating physician.

(d) Except to the extent expressly authorized by the patient or enrollee or subscriber or as provided by subdivisions (b) and (c), no provider of health care, health care service plan, or contractor shall intentionally share, sell, or otherwise use any medical information for any purpose not necessary to provide health care services to the patient.

(e) Except to the extent expressly authorized by the patient or enrollee or subscriber or as provided by subdivisions (b) and (c), no contractor shall further disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan or insurer or self-insured employer received under this section to any person or entity that is not engaged in providing direct health care services to the patient or his or her provider of health care or health care service plan or insurer or self-insured employer.

SEC. 2.1. Section 56.10 of the Civil Code is amended to read:

56.10. (a) No provider of health care, ~~or~~ health care service plan, or contractor shall disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization, except as provided in subdivision (b) or (c).

(b) A provider of health care, a health care service plan, or a contractor shall disclose medical information if the disclosure is compelled by any of the following:

(1) By a court pursuant to an order of that court.

(2) By a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority.

(3) By a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum, notice to appear served pursuant to Section 1987 of the Code of Civil Procedure, or any provision authorizing discovery in a proceeding before a court or administrative agency.

(4) By a board, commission, or administrative agency pursuant to an investigative subpoena issued under Article 2 (commencing with Section 11180) of Chapter 2 of Part 1 of Division 3 of Title 2 of the Government Code.

(5) By an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum issued under Section 1282.6 of the Code of Civil Procedure, or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.

(6) By a search warrant lawfully issued to a governmental law enforcement agency.

(7) By the patient or the patient's representative pursuant to Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(8) When otherwise specifically required by law.

(c) A provider of health care, or a health care service plan may disclose medical information as follows:

(1) The information may be disclosed to providers of health care, health care service plans, *contractors,* or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation, the communication of patient information by radio transmission *or other means* between emergency medical personnel at the scene of an emergency, or in an emergency medical transport vehicle, and emergency medical personnel at a health facility licensed pursuant to Chapter 2 (commencing with Section ~~1200)~~ *1250)* of Division 2 of the Health and Safety Code.

(2) The information may be disclosed to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, *contractor,* or any other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made. If (A) the patient is, by reason of a comatose or other disabling medical condition, unable to consent to the disclosure of medical information and (B) no other arrangements have been made to pay for the health care services being rendered to the patient, the information may be disclosed to a governmental authority to the extent necessary to determine the patient's eligibility for, and to obtain, payment under a governmental program for health care services provided to the patient. The information may also be disclosed to another provider of health care or health care service plan as necessary to assist the other provider or health care service plan in obtaining payment for health care services rendered by that provider of health care or health care service plan to the patient.

(3) The information may be disclosed to any person or entity that provides billing, claims management, medical data processing, or other administrative services for providers of health care or health care service plans or for any of the persons or entities specified in paragraph (2). However, no information so disclosed shall be further disclosed by the recipient in any way that would be violative of this part.

(4) The information may be disclosed to organized committees and agents of professional societies or of medical staffs of licensed hospitals, licensed health care service plans, professional standards review organizations, *independent medical review organizations and their selected reviewers,* utilization and quality control peer review organizations as established by Congress in Public Law 97-248 in 1982, *contractors,* or persons or organizations insuring, responsible for, or defending professional liability that a

provider may incur, if the committees, agents, *health care service* plans, organizations, *reviewers, contractors,* or persons are engaged in reviewing the competence or qualifications of health care professionals or in reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.

(5) The information in the possession of any provider of health care or health care service plan may be reviewed by any private or public body responsible for licensing or accrediting the provider of health care or health care service plan. However, no patient identifying medical information may be removed from the premises except as expressly permitted or required elsewhere by law*, nor shall that information be further disclosed by the recipient in any way that would violate this part*.

(6) The information may be disclosed to the county coroner in the course of an investigation by the coroner's office.

(7) The information may be disclosed to public agencies, clinical investigators, including investigators conducting epidemiologic studies, health care research organizations, and accredited public or private nonprofit educational or health care institutions for bona fide research purposes. However, no information so disclosed shall be further disclosed by the recipient in any way that would disclose the identity of any patient or be violative of this part.

(8) A provider of health care or health care service plan that has created medical information as a result of employment-related health care services to an employee conducted at the specific prior written request and expense of the employer may disclose to the employee's employer that part of the information that:

(A) Is relevant in a law suit, arbitration, grievance, or other claim or challenge to which the employer and the employee are parties and in which the patient has placed in issue his or her medical history, mental or physical condition, or treatment, provided that information may only be used or disclosed in connection with that proceeding.

(B) Describes functional limitations of the patient that may entitle the patient to leave from work for medical reasons or limit the patient's fitness to perform his or her present employment, provided that no statement of medical cause is included in the information disclosed.

(9) Unless the provider of health care or health care service plan is notified in writing of an agreement by the sponsor, insurer, or administrator to the contrary, the information may be disclosed to a sponsor, insurer, or administrator of a group or individual insured or uninsured plan or policy that the patient seeks coverage by or benefits from, if the information was created by the provider of health care or health care service plan as the result of services conducted at the specific prior written request and expense of the sponsor, insurer, or administrator for the purpose of evaluating the application for coverage or benefits.

(10) The information may be disclosed to a health care service plan by providers of health care that contract with the health care service plan and may be transferred among providers of health care that contract with the health care service plan, for the purpose of administering the health care service plan. Medical information may not otherwise be disclosed by a health care service plan except in accordance with the provisions of this part.

(11) Nothing in this part shall prevent the disclosure by a provider of health care or a health care service plan to an insurance institution, agent, or support organization, subject to Article 6.6 (commencing with Section 791) of Part 2 of Division 1 of the Insurance Code, of medical information if the insurance institution, agent, or support organization has complied with all requirements for obtaining the information pursuant to Article 6.6 (commencing with Section 791) of Part 2 of Division 1 of the Insurance Code.

(12) The information relevant to the patient's condition and care and treatment provided may be disclosed to a probate court investigator engaged in determining the need for an initial conservatorship or continuation of an existent conservatorship, if the patient

is unable to give informed consent, or to a probate court investigator, probation officer, or domestic relations investigator engaged in determining the need for an initial guardianship or continuation of an existent guardianship.

(13) The information may be disclosed to an organ procurement organization or a tissue bank processing the tissue of a decedent for transplantation into the body of another person, but only with respect to the donating decedent, for the purpose of aiding the transplant. For the purpose of this paragraph, the terms ''tissue bank'' and ''tissue'' have the same meaning as defined in Section 1635 of the Health and Safety Code.

(14) The information may be disclosed when the disclosure is otherwise specifically authorized by law, such as the voluntary reporting, either directly or indirectly, to the federal Food and Drug Administration of adverse events related to drug products or medical device problems.

(15) Basic information including the patient's name, city of residence, age, sex, and general condition may be disclosed to a state or federally recognized disaster relief organization for the purpose of responding to disaster welfare inquiries.

(16) The information may be disclosed to a third party for purposes of encoding, encrypting, or otherwise anonymizing data. However, no information so disclosed shall be further disclosed by the recipient in any way that would be violative of this part, including the unauthorized manipulation of coded or encrypted medical information that reveals individually identifiable medical information.

(17) For purposes of ~~chronic~~ disease management programs *and services as defined in Section 1399.901 of the Health and Safety Code*, information may be disclosed *as follows: (A)* to any entity contracting with a health care service plan *or the health care service plan's contractors* to monitor or administer care of enrollees for a covered benefit, provided that the disease management services and care are authorized by a treating physician,

or (B) to any disease management organization, as defined in Section 1399.900 of the Health and Safety Code, that complies fully with the physician authorization requirements of Section 1399.902 of the Health and Safety Code, provided that the health care service plan or its contractor provides or has provided a description of the disease management services to a treating physician or to the health care service plan's or contractor's network of physicians. Nothing in this paragraph shall be construed to require physician authorization for the care or treatment of the adherents of any well-recognized church or religious denomination who depend solely upon prayer or spiritual means for healing in the practice of the religion of that church or denomination.

(d) Except to the extent expressly authorized by the patient or enrollee or subscriber or as provided by subdivisions (b) and (c), no provider of health care, health care service plan, or contractor shall intentionally share, sell, or otherwise use any medical information for any purpose not necessary to provide health care services to the patient.

(e) Except to the extent expressly authorized by the patient or enrollee or subscriber or as provided by subdivisions (b) and (c), no contractor shall further disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan or insurer or self-insured employer received under this section to any person or entity that is not engaged in providing direct health care services to the patient or his or her provider of health care or health care service plan or insurer or self-insured employer.

SEC. 2.2. Section 56.10 of the Civil Code is amended to read:

56.10. (a) No provider of health care, ~~or~~ health care service plan, or contractor shall disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization, except as provided in subdivision (b) or (c).

(b) A provider of health care, a health care service plan, or a contractor shall disclose medical information if the disclosure is compelled by any of the following:

(1) By a court pursuant to an order of that court.

(2) By a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority.

(3) By a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum, notice to appear served pursuant to Section 1987 of the Code of Civil Procedure, or any provision authorizing discovery in a proceeding before a court or administrative agency.

(4) By a board, commission, or administrative agency pursuant to an investigative subpoena issued under Article 2 (commencing with Section 11180) of Chapter 2 of Part 1 of Division 3 of Title 2 of the Government Code.

(5) By an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum issued under Section 1282.6 of the Code of Civil Procedure, or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.

(6) By a search warrant lawfully issued to a governmental law enforcement agency.

(7) By the patient or the patient's representative pursuant to Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(8) When otherwise specifically required by law.

(c) A provider of health care, or a health care service plan may disclose medical information as follows:

(1) The information may be disclosed to providers of health care, health care service plans, *contractors,* or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation, the communication of patient information by radio transmission *or other means* between emergency medical personnel at the scene of an emergency, or in an emergency medical transport

vehicle, and emergency medical personnel at a health facility licensed pursuant to Chapter 2 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

(2) The information may be disclosed to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, *contractor,* or any other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made. If (A) the patient is, by reason of a comatose or other disabling medical condition, unable to consent to the disclosure of medical information and (B) no other arrangements have been made to pay for the health care services being rendered to the patient, the information may be disclosed to a governmental authority to the extent necessary to determine the patient's eligibility for, and to obtain, payment under a governmental program for health care services provided to the patient. The information may also be disclosed to another provider of health care or health care service plan as necessary to assist the other provider or health care service plan in obtaining payment for health care services rendered by that provider of health care or health care service plan to the patient.

(3) The information may be disclosed to any person or entity that provides billing, claims management, medical data processing, or other administrative services for providers of health care or health care service plans or for any of the persons or entities specified in paragraph (2). However, no information so disclosed shall be further disclosed by the recipient in any way that would be violative of this part.

(4) The information may be disclosed to organized committees and agents of professional societies or of medical staffs of licensed hospitals, licensed health care service plans, professional standards review organizations, *independent medical review organizations and their selected reviewers,* utilization

and quality control peer review organizations as established by Congress in Public Law 97-248 in 1982, *contractors,* or persons or organizations insuring, responsible for, or defending professional liability that a provider may incur, if the committees, agents, *health care service* plans, organizations, *reviewers, contractors,* or persons are engaged in reviewing the competence or qualifications of health care professionals or in reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.

(5) The information in the possession of any provider of health care or health care service plan may be reviewed by any private or public body responsible for licensing or accrediting the provider of health care or health care service plan. However, no patient identifying medical information may be removed from the premises except as expressly permitted or required elsewhere by law*, nor shall that information be further disclosed by the recipient in any way that would violate this part*.

(6) The information may be disclosed to the county coroner in the course of an investigation by the coroner's office.

(7) The information may be disclosed to public agencies, clinical investigators, including investigators conducting epidemiologic studies, health care research organizations, and accredited public or private nonprofit educational or health care institutions for bona fide research purposes. However, no information so disclosed shall be further disclosed by the recipient in any way that would disclose the identity of any patient or be violative of this part.

(8) A provider of health care or health care service plan that has created medical information as a result of employment-related health care services to an employee conducted at the specific prior written request and expense of the employer may disclose to the employee's employer that part of the information that:

(A) Is relevant in a law suit, arbitration, grievance, or other claim or challenge to which the employer and the employee are parties and in which the patient has placed

in issue his or her medical history, mental or physical condition, or treatment, provided that information may only be used or disclosed in connection with that proceeding.

(B) Describes functional limitations of the patient that may entitle the patient to leave from work for medical reasons or limit the patient's fitness to perform his or her present employment, provided that no statement of medical cause is included in the information disclosed.

(9) Unless the provider of health care or health care service plan is notified in writing of an agreement by the sponsor, insurer, or administrator to the contrary, the information may be disclosed to a sponsor, insurer, or administrator of a group or individual insured or uninsured plan or policy that the patient seeks coverage by or benefits from, if the information was created by the provider of health care or health care service plan as the result of services conducted at the specific prior written request and expense of the sponsor, insurer, or administrator for the purpose of evaluating the application for coverage or benefits.

(10) The information may be disclosed to a health care service plan by providers of health care that contract with the health care service plan and may be transferred among providers of health care that contract with the health care service plan, for the purpose of administering the health care service plan. Medical information may not otherwise be disclosed by a health care service plan except in accordance with the provisions of this part.

(11) Nothing in this part shall prevent the disclosure by a provider of health care or a health care service plan to an insurance institution, agent, or support organization, subject to Article 6.6 (commencing with Section 791) of Part 2 of Division 1 of the Insurance Code, of medical information if the insurance institution, agent, or support organization has complied with all requirements for obtaining the information pursuant to Article 6.6 (commencing with Section 791) of Part 2 of Division 1 of the Insurance Code.

(12) The information relevant to the patient's condition and care and treatment provided may be disclosed to a probate court investigator engaged in determining the need for an initial conservatorship or continuation of an existent conservatorship, if the patient is unable to give informed consent, or to a probate court investigator, probation officer, or domestic relations investigator engaged in determining the need for an initial guardianship or continuation of an existent guardianship.

(13) The information may be disclosed to an organ procurement organization or a tissue bank processing the tissue of a decedent for transplantation into the body of another person, but only with respect to the donating decedent, for the purpose of aiding the transplant. For the purpose of this paragraph, the terms ''tissue bank'' and ''tissue'' have the same meaning as defined in Section 1635 of the Health and Safety Code.

(14) The information may be disclosed when the disclosure is otherwise specifically authorized by law, such as the voluntary reporting, either directly or indirectly, to the federal Food and Drug Administration of adverse events related to drug products or medical device problems.

(15) Basic information including the patient's name, city of residence, age, sex, and general condition may be disclosed to a state or federally recognized disaster relief organization for the purpose of responding to disaster welfare inquiries.

(16) The information may be disclosed to a third party for purposes of encoding, encrypting, or otherwise anonymizing data. However, no information so disclosed shall be further disclosed by the recipient in any way that would be violative of this part, including the unauthorized manipulation of coded or encrypted medical information that reveals individually identifiable medical information.

(17) For purposes of chronic disease management programs, information may be disclosed to any entity contracting with a health care service plan to monitor or

administer care of enrollees for a covered benefit, provided that the disease management services and care are authorized by a treating physician.

(d) Except to the extent expressly authorized by the patient or enrollee or subscriber or as provided by subdivisions (b) and (c), no provider of health care, health care service ~~plan, or contractor~~ *plan contractor, or corporation and its subsidiaries and affiliates* shall intentionally share, sell, or otherwise use any medical information for any purpose not necessary to provide health care services to the patient.

(e) Except to the extent expressly authorized by the patient or enrollee or subscriber or as provided by subdivisions (b) and (c), no contractor *or corporation and its subsidiaries and affiliates* shall further disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan or insurer or self-insured employer received under this section to any person or entity that is not engaged in providing direct health care services to the patient or his or her provider of health care or health care service plan or insurer or self-insured employer.

SEC. 2.3. Section 56.10 of the Civil Code is amended to read:

56.10. (a) No provider of health care, ~~or~~ health care service plan, or contractor shall disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization, except as provided in subdivision (b) or (c).

(b) A provider of health care, a health care service plan, or a contractor shall disclose medical information if the disclosure is compelled by any of the following:

(1) By a court pursuant to an order of that court.

(2) By a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority.

(3) By a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum, notice to appear served pursuant to Section

1987 of the Code of Civil Procedure, or any provision authorizing discovery in a proceeding before a court or administrative agency.

(4) By a board, commission, or administrative agency pursuant to an investigative subpoena issued under Article 2 (commencing with Section 11180) of Chapter 2 of Part 1 of Division 3 of Title 2 of the Government Code.

(5) By an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum issued under Section 1282.6 of the Code of Civil Procedure, or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.

(6) By a search warrant lawfully issued to a governmental law enforcement agency.

(7) By the patient or the patient's representative pursuant to Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(8) When otherwise specifically required by law.

(c) A provider of health care, or a health care service plan may disclose medical information as follows:

(1) The information may be disclosed to providers of health care, health care service plans, *contractor's* or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation, the communication of patient information by radio transmission *or other means* between emergency medical personnel at the scene of an emergency, or in an emergency medical transport vehicle, and emergency medical personnel at a health facility licensed pursuant to Chapter 2 (commencing with Section ~~1200)~~ *1250)* of Division 2 of the Health and Safety Code.

(2) The information may be disclosed to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, *contractor* or any other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for

payment to be determined and payment to be made. If (A) the patient is, by reason of a comatose or other disabling medical condition, unable to consent to the disclosure of medical information and (B) no other arrangements have been made to pay for the health care services being rendered to the patient, the information may be disclosed to a governmental authority to the extent necessary to determine the patient's eligibility for, and to obtain, payment under a governmental program for health care services provided to the patient. The information may also be disclosed to another provider of health care or health care service plan as necessary to assist the other provider or health care service plan in obtaining payment for health care services rendered by that provider of health care or health care service plan to the patient.

(3) The information may be disclosed to any person or entity that provides billing, claims management, medical data processing, or other administrative services for providers of health care or health care service plans or for any of the persons or entities specified in paragraph (2). However, no information so disclosed shall be further disclosed by the recipient in any way that would be violative of this part.

(4) The information may be disclosed to organized committees and agents of professional societies or of medical staffs of licensed hospitals, licensed health care service plans, professional standards review organizations, *independent medical review organizations and their selected reviewers* utilization and quality control peer review organizations as established by Congress in Public Law 97-248 in 1982, *contractors* or persons or organizations insuring, responsible for, or defending professional liability that a provider may incur, if the committees, agents, *health care service* plans, organizations, *reviewers, contractors* or persons are engaged in reviewing the competence or qualifications of health care professionals or in reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.

(5) The information in the possession of any provider of health care or health care service plan may be reviewed by any private or public body responsible for licensing or accrediting the provider of health care or health care service plan. However, no patient identifying medical information may be removed from the premises except as expressly permitted or required elsewhere by law*, nor shall that information be further disclosed by the recipient in any way that would violate this part*.

(6) The information may be disclosed to the county coroner in the course of an investigation by the coroner's office.

(7) The information may be disclosed to public agencies, clinical investigators, including investigators conducting epidemiologic studies, health care research organizations, and accredited public or private nonprofit educational or health care institutions for bona fide research purposes. However, no information so disclosed shall be further disclosed by the recipient in any way that would disclose the identity of any patient or be violative of this part.

(8) A provider of health care or health care service plan that has created medical information as a result of employment-related health care services to an employee conducted at the specific prior written request and expense of the employer may disclose to the employee's employer that part of the information that:

(A) Is relevant in a law suit, arbitration, grievance, or other claim or challenge to which the employer and the employee are parties and in which the patient has placed in issue his or her medical history, mental or physical condition, or treatment, provided that information may only be used or disclosed in connection with that proceeding.

(B) Describes functional limitations of the patient that may entitle the patient to leave from work for medical reasons or limit the patient's fitness to perform his or her present employment, provided that no statement of medical cause is included in the information disclosed.

(9) Unless the provider of health care or health care service plan is notified in writing of an agreement by the sponsor, insurer, or administrator to the contrary, the information may be disclosed to a sponsor, insurer, or administrator of a group or individual insured or uninsured plan or policy that the patient seeks coverage by or benefits from, if the information was created by the provider of health care or health care service plan as the result of services conducted at the specific prior written request and expense of the sponsor, insurer, or administrator for the purpose of evaluating the application for coverage or benefits.

(10) The information may be disclosed to a health care service plan by providers of health care that contract with the health care service plan and may be transferred among providers of health care that contract with the health care service plan, for the purpose of administering the health care service plan. Medical information may not otherwise be disclosed by a health care service plan except in accordance with the provisions of this part.

(11) Nothing in this part shall prevent the disclosure by a provider of health care or a health care service plan to an insurance institution, agent, or support organization, subject to Article 6.6 (commencing with Section 791) of Part 2 of Division 1 of the Insurance Code, of medical information if the insurance institution, agent, or support organization has complied with all requirements for obtaining the information pursuant to Article 6.6 (commencing with Section 791) of Part 2 of Division 1 of the Insurance Code.

(12) The information relevant to the patient's condition and care and treatment provided may be disclosed to a probate court investigator engaged in determining the need for an initial conservatorship or continuation of an existent conservatorship, if the patient is unable to give informed consent, or to a probate court investigator, probation officer, or domestic relations investigator engaged in determining the need for an initial guardianship or continuation of an existent guardianship.

(13) The information may be disclosed to an organ procurement organization or a tissue bank processing the tissue of a decedent for transplantation into the body of another person, but only with respect to the donating decedent, for the purpose of aiding the transplant. For the purpose of this paragraph, the terms ‘‘tissue bank’’ and ‘‘tissue’’ have the same meaning as defined in Section 1635 of the Health and Safety Code.

(14) The information may be disclosed when the disclosure is otherwise specifically authorized by law, such as the voluntary reporting, either directly or indirectly, to the federal Food and Drug Administration of adverse events related to drug products or medical device problems.

(15) Basic information including the patient’s name, city of residence, age, sex, and general condition may be disclosed to a state or federally recognized disaster relief organization for the purpose of responding to disaster welfare inquiries.

(16) The information may be disclosed to a third party for purposes of encoding, encrypting, or otherwise anonymizing data. However, no information so disclosed shall be further disclosed by the recipient in any way that would be violative of this part, including the unauthorized manipulation of coded or encrypted medical information that reveals individually identifiable medical information.

(17) For purposes of ~~chronic~~ disease management programs *and services as defined in Section 1399.901 of the Health and Safety Code*, information may be disclosed *as follows: (A)* to any entity contracting with a health care service plan *or the health care service plan’s contractors* to monitor or administer care of enrollees for a covered benefit, provided that the disease management services and care are authorized by a treating physician*, or (B) to any disease management organization, as defined in Section 1399.900 of the Health and Safety Code, that complies fully with the physician authorization requirements of Section 1399.902 of the Health and Safety Code, provided that the health care service plan or its*

contractor provides or has provided a description of the disease management services to a treating physician or to the health care service plan's or contractor's network of physicians. Nothing in this paragraph shall be construed to require physician authorization for the care or treatment of the adherents of any well-recognized church or religious denomination who depend solely upon prayer or spiritual means for healing in the practice of the religion of that church or denomination.

(d) Except to the extent expressly authorized by the patient or enrollee or subscriber or as provided by subdivisions (b) and (c), no provider of health care, health care service ~~plan, or contractor~~ *plan contractor, or corporation and its subsidiaries and affiliates* shall intentionally share, sell, or otherwise use any medical information for any purpose not necessary to provide health care services to the patient.

(e) Except to the extent expressly authorized by the patient or enrollee or subscriber or as provided by subdivisions (b) and (c), no contractor *or corporation and its subsidiaries and affiliates* shall further disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan or insurer or self-insured employer received under this section to any person or entity that is not engaged in providing direct health care services to the patient or his or her provider of health care or health care service plan or insurer or self-insured employer.

SEC. 3. Section 56.30 of the Civil Code is amended to read:

56.30. The disclosure and use of the following medical information shall not be subject to the limitations of this part:

(a) (Mental health and developmental disabilities) Information and records obtained in the course of providing services under Division 4 (commencing with Section 4000), Division 4.1 (commencing with Section 4400), Division 4.5 (commencing with Section 4500), Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7

(commencing with Section 7100) of the Welfare and Institutions Code.

(b) (Public social services) Information and records that are subject to Sections 10850, 14124.1, and 14124.2 of the Welfare and Institutions Code.

(c) (State health services, communicable diseases, developmental disabilities) Information and records maintained pursuant to former Chapter 2 (commencing with Section 200) of Part 1 of Division 1 of the Health and Safety Code and pursuant to the Communicable Disease Prevention and Control Act (subdivision (a) of Section 27 of the Health and Safety Code).

(d) (Licensing and statistics) Information and records maintained pursuant to Division 2 (commencing with Section 1200) and Part 1 (commencing with Section 102100) of Division 102 of the Health and Safety Code; pursuant to Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code; and pursuant to Section 8608, 8817, or 8909 of the Family Code.

(e) (Medical survey, workers' safety) Information and records acquired and maintained or disclosed pursuant to Sections 1380 and 1382 of the Health and Safety Code and pursuant to Division 5 (commencing with Section 6300) of the Labor Code.

(f) (Industrial accidents) Information and records acquired, maintained, or disclosed pursuant to Division 1 (commencing with Section 50), Division 4 (commencing with Section 3200), Division 4.5 (commencing with Section 6100), and Division 4.7 (commencing with Section 6200) of the Labor Code.

(g) (Law enforcement) Information and records maintained by a health facility which are sought by a law enforcement agency under Chapter 3.5 (commencing with Section 1543) of Title 12 of Part 2 of the Penal Code.

(h) (Investigations of employment accident or illness) Information and records sought as part of an investigation of an on-the-job accident or illness pursuant to Division 5 (commencing with Section 6300) of the Labor Code or pursuant to Section 105200 of the Health and Safety Code.

(i) (Alcohol or drug abuse) Information and records subject to the federal alcohol and drug abuse regulations (Part 2 (commencing with Section 2.1) of subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations) or to Section 11977 of the Health and Safety Code dealing with narcotic and drug abuse.

(j) (Patient discharge data) Nothing in this part shall be construed to limit, expand, or otherwise affect the authority of the California Health Facilities Commission to collect patient discharge information from health facilities.

(k) Medical information and records disclosed to, and their use by, the Insurance Commissioner, the Director of the Department of Managed Health Care, the Division of Industrial Accidents, the Workers' Compensation Appeals Board, the Department of Insurance, or the Department of Managed Health Care.

Sec. 4. Section 56.101 of the Civil Code is amended to read:

56.101. Every provider of health care, health care service plan, or contractor who creates, maintains, preserves, stores, abandons, destroys, or disposes of medical records shall do so in a manner that preserves the confidentiality of the information contained therein. Any provider of health care, health care service plan, or contractor who negligently creates, maintains, preserves, stores, abandons, destroys, or disposes of medical records shall be subject to the remedies and penalties provided under subdivisions (b) and (c) of Section 56.36.

SEC. 5. Section 1347.15 of the Health and Safety Code is amended to read:

1347.15. (a) There is hereby established in the Department of Managed Health Care the Financial Solvency Standards Board composed of eight members. The members shall consist of the director, or the director's designee, and seven members appointed by the director. The seven members appointed by the director may be, but are not necessarily limited to, individuals with training and experience in the following subject areas or fields: medical and health care economics;

accountancy, with experience in integrated or affiliated health care delivery systems; excess loss insurance underwriting in the medical, hospital, and health plan business; actuarial studies in the area of health care delivery systems; management and administration in integrated or affiliated health care delivery systems; investment banking; and information technology in integrated or affiliated health care delivery systems. The members appointed by the director shall be appointed for a term of three years, but may be removed or reappointed by the director before the expiration of the term.

(b) The purpose of the board is to do all of the following:

(1) Advise the director on matters of financial solvency affecting the delivery of health care services.

(2) Develop and recommend to the director financial solvency requirements and standards relating to plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships, and provider-affiliate operations and transactions.

(3) Periodically monitor and report on the implementation and results of the financial solvency requirements and standards.

(c) Financial solvency requirements and standards recommended to the director by the board may, after a period of review and comment not to exceed 45 days and, notwithstanding Section 1347, be noticed for adoption as regulations as proposed or modified under the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). During the director's 45-day review and comment period, the director, in consultation with the board, may postpone the adoption of the requirements and standards pending further review and comment. Within five business days of receipt by the director of the recommendation of the board, the director shall send an information only copy of the recommendations to the members of the Advisory Committee on Managed Care. Nothing in this subdivision prohibits the director from

adopting regulations, including emergency regulations, under the rulemaking provisions of the Administrative Procedure Act.

(d) Except as provided in subdivision (e), the board shall meet at least quarterly and at the call of the chair. In order to preserve the independence of the board, the director shall not serve as chair. The members of the board may establish their own rules and procedures. All members shall serve without compensation, but shall be reimbursed from department funds for expenses actually and necessarily incurred in the performance of their duties.

(e) During the two years from the date of the first meeting of the board, the board shall meet monthly in order to expeditiously fulfill its purpose under paragraphs (1) and (2) of subdivision (b).

(f) For purposes of this section, ''board'' means the Financial Solvency Standards Board.

SEC. 6. Section 1363.5 of the Health and Safety Code is amended to read:

1363.5. (a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management

functions, to determine whether to authorize, modify, or deny health care services shall:

(1) Be developed with involvement from actively practicing health care providers.

(2) Be consistent with sound clinical principles and processes.

(3) Be evaluated, and updated if necessary, at least annually.

(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

(5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

(c) The disclosure required by paragraph (5) of subdivision (b) shall be accompanied by the following notice: ''The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.''

SEC. 7. Section 1364.5 of the Health and Safety Code is amended to read:

1364.5. (a) On or before July 1, 2001, every health care service plan shall file with the director a copy of their policies and procedures to protect the security of patient medical information to ensure compliance with the Confidentiality of Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code). Any amendment to the policies and procedures shall be filed in accordance with Section 1352.

(b) On and after July 1, 2001, every health care service plan shall, upon request, provide to enrollees and

subscribers a written statement that describes how the contracting organization or health care service plan maintains the confidentiality of medical information obtained by and in the possession of the contracting organization or the health care service plan.

(c) The statement required by subdivision (b) shall be in at least 12-point type and meet the following requirements:

(1) The statement shall describe how the contracting organization or health care service plan protects the confidentiality of medical information pursuant to this article and inform patients or enrollees and subscribers that any disclosure of medical information beyond the provisions of the law is prohibited.

(2) The statement shall describe the types of medical information that may be collected and the type of sources that may be used to collect the information, the purposes for which the contracting organization or plan will obtain medical information from other health care providers.

(3) The statement shall describe the circumstances under which medical information may be disclosed without prior authorization, pursuant to Section 56.10 of the Civil Code.

(4) The statement shall describe how patients or enrollees and subscribers may obtain access to medical information created by and in the possession of the contracting organization or health care service plan, including copies of medical information.

(d) On and after July 1, 2001, every health care service plan shall include in its evidence of coverage or disclosure form the following notice, in 12-point type:

> A STATEMENT DESCRIBING (NAME OR PLAN OR ''OUR'') POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

SEC. 8. Section 1367.01 of the Health and Safety Code is amended to read:

1367.01. (a) Every health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) Every health care service plan subject to this section shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director

or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, every health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be

communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid

paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the State Managed Care Fund.

(i) Every health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) Every health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(*l*) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 9. Section 1367.5 of the Health and Safety Code is repealed.

SEC. 10. Section 1367.51 of the Health and Safety Code is amended to read:

1367.51. (a) Every health care service plan contract, except a specialized health care service plan contract,

that is issued, amended, delivered, or renewed on or after January 1, 2000, and that covers hospital, medical, or surgical expenses shall include coverage for the following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription:

(1) Blood glucose monitors and blood glucose testing strips.

(2) Blood glucose monitors designed to assist the visually impaired.

(3) Insulin pumps and all related necessary supplies.

(4) Ketone urine testing strips.

(5) Lancets and lancet puncture devices.

(6) Pen delivery systems for the administration of insulin.

(7) Podiatric devices to prevent or treat diabetes-related complications.

(8) Insulin syringes.

(9) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

(b) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits shall include coverage for the following prescription items if the items are determined to be medically necessary:

(1) Insulin.

(2) Prescriptive medications for the treatment of diabetes.

(3) Glucagon.

(c) The copayments and deductibles for the benefits specified in subdivisions (a) and (b) shall not exceed those established for similar benefits within the given plan.

(d) Every plan shall provide coverage for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable an enrollee to properly use the equipment, supplies, and medications set forth in subdivisions (a) and (b), and additional

diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the enrollee's participating physician. If a plan delegates outpatient self-management training to contracting providers, the plan shall require contracting providers to ensure that diabetes outpatient self-management training, education, and medical nutrition therapy are provided by appropriately licensed or registered health care professionals.

(e) The diabetes outpatient self-management training, education, and medical nutrition therapy services identified in subdivision (d) shall be provided by appropriately licensed or registered health care professionals as prescribed by a participating health care professional legally authorized to prescribe the service. These benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.

(f) The copayments for the benefits specified in subdivision (d) shall not exceed those established for physician office visits by the plan.

(g) Every health care service plan governed by this section shall disclose the benefits covered pursuant to this section in the plan's evidence of coverage and disclosure forms.

(h) A health care service plan may not reduce or eliminate coverage as a result of the requirements of this section.

SEC. 11. Section 1368 of the Health and Safety Code is amended to read:

1368. (a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate

consideration of enrollee grievances and rectification when appropriate.

(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(3) Provide forms for grievances to be given to subscribers and enrollees who wish to register written grievances. The forms used by plans licensed pursuant to Section 1353 shall be approved by the director in advance as to format.

(4) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

(5) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.

(b) (1) (A) After either completing the grievance process described in subdivision (a), or participating in the process for at least 30 days, a subscriber or enrollee may submit the grievance to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or

participate in the process for at least 30 days before submitting a grievance to the department for review.

(B) A grievance may be submitted to the department for review and resolution prior to any arbitration.

(C) Notwithstanding subparagraphs (A) and (B), the department may refer any grievance that does not pertain to compliance with this chapter to the State Department of Health Services, the California Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

(2) If the subscriber or enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the subscriber or enrollee, as appropriate, may submit the grievance to the department as the agent of the subscriber or enrollee. Further, a provider may join with, or otherwise assist, a subscriber or enrollee, or the agent, to submit the grievance to the department. In addition, following submission of the grievance to the department, the subscriber or enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the subscriber or enrollee. For purposes of this section, a ''relative'' includes the parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the subscriber or enrollee.

(3) The department shall review the written documents submitted with the subscriber's or the enrollee's request for review, or submitted by the agent on behalf of the subscriber or enrollee. The department may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the subscriber or enrollee. If after reviewing the record, the department concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department shall immediately notify the subscriber or enrollee, or

agent, of that option and shall, if requested orally or in writing, assist the subscriber or enrollee in participating in the independent medical review system.

(4) If after reviewing the record of a grievance, the department concludes that a health care service eligible for coverage and payment under a health care service plan contract has been delayed, denied, or modified by a plan, or by one of its contracting providers, in whole or in part due to a determination that the service is not medically necessary, and that determination was not communicated to the enrollee in writing along with a notice of the enrollee's potential right to participate in the independent medical review system, as required by this chapter, the director shall, by order, assess administrative penalties. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the State Managed Care Fund.

(5) The department shall send a written notice of the final disposition of the grievance, and the reasons therefor, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within 30 calendar days of receipt of the request for review unless the director, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. In any case not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department's written notice shall include, at a minimum, the following:

(A) A summary of its findings and the reasons why the department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the director.

(B) A discussion of the department's contact with any medical provider, or any other independent expert relied on by the department, along with a summary of the views and qualifications of that provider or expert.

(C) If the enrollee's grievance is sustained in whole or part, information about any corrective action taken.

(6) In any department review of a grievance involving a disputed health care service, as defined in subdivision (b) of Section 1374.30, that is not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), in which the department finds that the plan has delayed, denied, or modified health care services that are medically necessary, based on the specific medical circumstances of the enrollee, and those services are a covered benefit under the terms and conditions of the health care service plan contract, the department's written notice shall either: (A) order the plan to promptly offer and provide those health care services to the enrollee, or (B) order the plan to promptly reimburse the enrollee for any reasonable costs associated with urgent care or emergency services, or other extraordinary and compelling health care services, when the department finds that the enrollee's decision to secure those services outside of the plan network was reasonable under the circumstances. The department's order shall be binding on the plan.

(7) Distribution of the written notice shall not be deemed a waiver of any exemption or privilege under existing law, including, but not limited to, Section 6254.5 of the Government Code, for any information in connection with and including the written notice, nor shall any person employed or in any way retained by the department be required to testify as to that information or notice.

(8) The director shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more, that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

(9) A subscriber or enrollee, or the agent acting on behalf of a subscriber or enrollee, may also request voluntary mediation with the plan prior to exercising the right to submit a grievance to the department. The use of mediation services shall not preclude the right to submit a grievance to the department upon completion of mediation. In order to initiate mediation, the subscriber or enrollee, or the agent acting on behalf of the subscriber or enrollee, and the plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

(c) The plan's grievance system shall include a system of aging of grievances that are pending and unresolved for 30 days or more. The plan shall provide a quarterly report to the director of grievances pending and unresolved for 30 or more days with separate categories of grievances for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more. The plan may include the following statement in the quarterly report that is made available to the public by the director:

> ''Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights.''

If requested by a plan, the director shall include this statement in a written report made available to the public and prepared by the director that describes or compares grievances that are pending and unresolved with the plan for 30 days or more. Additionally, the director shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the

reasons why grievances described in that written report are pending and unresolved for 30 days or more. The director shall not be required to include a statement or append a brief explanation to a written report that the director is required to prepare under this chapter, including Sections 1380 and 1397.5.

(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

(e) Nothing in this section shall be construed to allow the submission to the department of any provider grievance under this section. However, as part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this subdivision shall be construed to prohibit a provider from contacting and informing the department about any concerns he or she has regarding compliance with or enforcement of this chapter.

SEC. 12. Section 1368.04 of the Health and Safety Code is amended to read:

1368.04. (a) The director shall investigate and take enforcement action against plans regarding grievances reviewed and found by the department to involve noncompliance with the requirements of this chapter, including grievances that have been reviewed pursuant to the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30). Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director shall, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the State Managed Care

Fund. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(b) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(1) Repeated failure to act promptly and reasonably to investigate and resolve grievances in accordance with Section 1368.01.

(2) Repeated failure to act promptly and reasonably to resolve grievances when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(c) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

(d) The administrative penalties authorized pursuant to this section shall be paid to the State Managed Care Fund.

SEC. 13. Section 1370.4 of the Health and Safety Code is amended to read:

1370.4. (a) Every health care service plan shall provide an external, independent review process to examine the plan's coverage decisions regarding experimental or investigational therapies for individual enrollees who meet all of the following criteria:

(1) (A) The enrollee has a life-threatening or seriously debilitating condition.

(B) For purposes of this section, ''life-threatening'' means either or both of the following:

(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(C) For purposes of this section, ‘‘seriously debilitating’’ means diseases or conditions that cause major irreversible morbidity.

(2) The enrollee’s physician certifies that the enrollee has a condition, as defined in paragraph (1), for which standard therapies have not been effective in improving the condition of the enrollee, for which standard therapies would not be medically appropriate for the enrollee, or for which there is no more beneficial standard therapy covered by the plan than the therapy proposed pursuant to paragraph (3).

(3) Either (A) the enrollee’s physician, who is under contract with or employed by the plan, has recommended a drug, device, procedure or other therapy that the physician certifies in writing is likely to be more beneficial to the enrollee than any available standard therapies, or (B) the enrollee, or the enrollee’s physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the enrollee’s condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in subdivision (d), is likely to be more beneficial for the enrollee than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require the plan to pay for the services of a nonparticipating physician provided pursuant to this subdivision, that are not otherwise covered pursuant to the plan contact.

(4) The enrollee has been denied coverage by the plan for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph (3).

(5) The specific drug, device, procedure, or other therapy recommended pursuant to paragraph (3) would

be a covered service, except for the plan's determination that the therapy is experimental or investigational.

(b) The plan's decision to delay, deny, or modify experimental or investigational therapies shall be subject to the independent medical review process under Article 5.55 (commencing with Section 1374.30) except that, in lieu of the information specified in subdivision (b) of Section 1374.33, an independent medical reviewer shall base his or her determination on relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence defined in subdivision (d).

(c) The independent medical review process shall also meet the following criteria:

(1) The plan shall notify eligible enrollees in writing of the opportunity to request the external independent review within five business days of the decision to deny coverage.

(2) If the enrollee's physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall be rendered within seven days of the request for expedited review. At the request of the expert, the deadline shall be extended by up to three days for a delay in providing the documents required. The timeframes specified in this paragraph shall be in addition to any otherwise applicable timeframes contained in subdivision (c) of Section 1374.33.

(3) Each expert's analysis and recommendation shall be in written form and state the reasons the requested therapy is or is not likely to be more beneficial for the enrollee than any available standard therapy, and the reasons that the expert recommends that the therapy should or should not be provided by the plan, citing the enrollee's specific medical condition, the relevant documents provided, and the relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence as defined in subdivision (d), to support the expert's recommendation.

(4) Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to other benefits under the plan contract.

(d) For the purposes of subdivision (b), ''medical and scientific evidence'' means the following sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(2) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base Health Services Technology Assessment Research (HSTAR).

(3) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.

(4) The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information.

(5) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(6) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

(e) The independent review process established by this section shall be required on and after January 1, 2001.

SEC. 14. Section 1375.4 of the Health and Safety Code is amended to read:

1375.4. (a) Every contract between a health care service plan and a risk-bearing organization that is issued, amended, renewed, or delivered in this state on or after July 1, 2000, shall include provisions concerning the following, as to the risk-bearing organization's administrative and financial capacity, which shall be effective as of January 1, 2001:

(1) A requirement that the risk-bearing organization furnish financial information to the health care service plan or the plan's designated agent and meet any other financial requirements that assist the health care service plan in maintaining the financial viability of its arrangements for the provision of health care services in a manner that does not adversely affect the integrity of the contract negotiation process.

(2) A requirement that the health care service plan disclose information to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the financial risk assumed under the contract.

(3) A requirement that the health care service plans provide payments of all risk arrangements, excluding capitation, within 180 days after close of the fiscal year.

(b) In accordance with subdivision (a) of Section 1344, the director shall adopt regulations on or before June 30, 2000, to implement this section which shall, at a minimum, provide for the following:

(1) (A) A process for reviewing or grading risk-bearing organizations based on the following criteria:

(i) The risk-bearing organization meets criterion 1 if it reimburses, contests, or denies claims for health care services it has provided, arranged, or for which it is otherwise financially responsible in accordance with the timeframes and other requirements described in Section

1371 and in accordance with any other applicable state and federal laws and regulations.

(ii) The risk-bearing organization meets criterion 2 if it estimates its liability for incurred but not reported claims pursuant to a method that has not been held objectionable by the director, records the estimate at least quarterly as an accrual in its books and records, and appropriately reflects this accrual in its financial statements.

(iii) The risk-bearing organization meets criterion 3 if it maintains at all times a positive tangible net equity, as defined in subdivision (e) of Section 1300.76 of Title 10 of the California Code of Regulations.

(iv) The risk-bearing organization meets criterion 4 if it maintains at all times a positive level of working capital (excess of current assets over current liabilities).

(B) A risk-bearing organization may reduce its liabilities for purposes of calculating tangible net equity, pursuant to clause (iii) of subparagraph (A), and working capital, pursuant to clause (iv) of subparagraph (A), by the amount of any liabilities the payment of which is guaranteed by a sponsoring organization pursuant to a qualified guarantee. A sponsoring organization is one that has a tangible net equity of a level to be established by the director that is in excess of all amounts that it has guaranteed to any person or entity. A qualified guarantee is one that meets all of the following:

(i) It is approved by a board resolution of the sponsoring organization.

(ii) The sponsoring organization agrees to submit audited annual financial statements to the plan within 120 days of the end of the sponsoring organization’s fiscal year.

(iii) The guarantee is unconditional except for a maximum monetary limit.

(iv) The guarantee is not limited in duration with respect to liabilities arising during the term of the guarantee.

(v) The guarantee provides for six months’ advance notice to the plan prior to its cancellation.

(2) The information required from risk-bearing organizations to assist in reviewing or grading these risk-bearing organizations, including balance sheets, claims reports, and designated annual, quarterly, or monthly financial statements prepared in accordance with generally accepted accounting principles, to be used in a manner, and to the extent necessary, provided to a single external party as approved by the director to the extent that it does not adversely affect the integrity of the contract negotiation process between the health care service plan and the risk-bearing organizations.

(3) Audits to be conducted in accordance with generally accepted auditing standards and in a manner that avoids duplication of review of the risk-bearing organization.

(4) A process for corrective action plans, as mutually agreed upon by the health care service plan and the risk-bearing organization and as approved by the director, for cases where the review or grading indicates deficiencies that need to be corrected by the risk-bearing organization, and contingency plans to ensure the delivery of health care services if the corrective action fails. The corrective action plan shall be approved by the director and standardized, to the extent possible, to meet the needs of the director and all health care service plans contracting with the risk-bearing organization. If the health care service plan and the risk-bearing organization are unable to determine a mutually agreeable corrective action plan, the director shall determine the corrective action plan.

(5) The disclosure of information by health care service plans to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the risk assumed under the contract, including:

(A) Enrollee information monthly.

(B) Risk arrangement information, information pertaining to any pharmacy risk assumed under the contract, information regarding incentive payments, and information on income and expenses assigned to the risk-bearing organization quarterly.

(6) Periodic reports from each health care service plan to the director that include information concerning the risk-bearing organizations and the type and amount of financial risk assumed by them, and, if deemed necessary and appropriate by the director, a registration process for the risk-bearing organizations.

(7) The confidentiality of financial and other records to be produced, disclosed, or otherwise made available, unless as otherwise determined by the director.

(c) The failure by a health care service plan to comply with the contractual requirements pursuant to this section shall constitute grounds for disciplinary action. The director shall, as appropriate, within 60 days after receipt of documented violation from a risk-bearing organization, investigate and take enforcement action against a health care service plan that fails to comply with these requirements and shall periodically evaluate contracts between health care service plans and risk-bearing organizations to determine if any audit, evaluation, or enforcement actions should be undertaken by the department.

(d) The Financial Solvency Standards Board established in Section 1347.15 shall study and report to the director on or before January 1, 2001, regarding all of the following:

(1) The feasibility of requiring that there be in force insurance coverage commensurate with the financial risk assumed by the risk-bearing organization to protect against financial losses.

(2) The appropriateness of different risk-bearing arrangements between health care service plans and risk-bearing organizations.

(3) The appropriateness of the four criteria specified in paragraph (1) of subdivision (b).

(e) This section shall not apply to specialized health care service plans.

(f) For purposes of this section, ‘‘provider organization’’ means a medical group, independent practice association, or other entity that delivers,

furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a plan.

(g) (1) For the purposes of this section, a ''risk-bearing organization'' means a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (*l*) of Section 1206, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a health care service plan, and that does all of the following:

(A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees.

(B) Receives compensation for those services on any capitated or fixed periodic payment basis.

(C) Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization. Nothing in this subparagraph in any way limits, alters, or abrogates any responsibility of a health care service plan under existing law.

(2) Notwithstanding paragraph (1), risk-bearing organizations shall not be deemed to include a provider organization that meets either of the following requirements:

(A) The health care service plan files with the department consolidated financial statements that include the provider organization.

(B) The health care service plan is the only health care service plan with which the provider organization contracts for arranging or providing health care services and, during the previous and current fiscal years, the provider organization's maximum potential expenses for providing or arranging for health care services did not exceed 115 percent of its maximum potential revenue for providing or arranging for those services.

(h) For purposes of this section, ‘‘claims’’ include, but are not limited to, contractual obligations to pay capitation or payments on a managed hospital payment basis.

SEC. 15. Section 1386 of the Health and Safety Code is amended to read:

1386. (a) The director may, after appropriate notice and opportunity for a hearing, by order suspend or revoke any license issued under this chapter to a health care service plan or assess administrative penalties if the director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action.

(b) The following acts or omissions constitute grounds for disciplinary action by the director:

(1) The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.

(2) The plan has issued, or permits others to use, evidence of coverage or uses a schedule of charges for health care services which do not comply with those published in the latest evidence of coverage found unobjectionable by the director.

(3) The plan does not provide basic health care services to its enrollees and subscribers as set forth in the evidence of coverage. This subdivision shall not apply to specialized health care service plan contracts.

(4) The plan is no longer able to meet the standards set forth in Article 5 (commencing with Section 1367).

(5) The continued operation of the plan will constitute a substantial risk to its subscribers and enrollees.

(6) The plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted

by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter.

(7) The plan has engaged in any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code.

(8) The plan has permitted, or aided or abetted any violation by an employee or contractor who is a holder of any certificate, license, permit, registration or exemption issued pursuant to the Business and Professions Code, or this code which would constitute grounds for discipline against the certificate, license, permit, registration, or exemption.

(9) The plan has aided or abetted or permitted the commission of any illegal act.

(10) The engagement of a person as an officer, director, employee, associate, or provider of the plan contrary to the provisions of an order issued by the director pursuant to subdivision (c) of this section or subdivision (d) of Section 1388.

(11) The engagement of a person as a solicitor or supervisor of solicitation contrary to the provisions of an order issued by the director pursuant to Section 1388.

(12) The plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the plan, management company or affiliate, has been convicted of or pleaded nolo contendere to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with this chapter. The director may revoke or deny a license hereunder irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.

(13) The plan violates Section 510, 2056, or 2056.1 of the Business and Professions Code.

(14) The plan has been subject to a final disciplinary action taken by this state, another state, an agency of the

federal government, or another country, for any act or omission that would constitute a violation of this chapter.

(15) The plan violates the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(c) (1) The director may prohibit any person from serving as an officer, director, employee, associate, or provider of any plan or solicitor firm, or of any management company of any plan, or as a solicitor, if either of the following applies:

(A) The prohibition is in the public interest and the person has committed, caused, participated in, or had knowledge of a violation of this chapter by a plan, management company, or solicitor firm.

(B) The person was an officer, director, employee, associate, or provider of a plan or of a management company or solicitor firm of any plan whose license has been suspended or revoked pursuant to this section and the person had knowledge of, or participated in, any of the prohibited acts for which the license was suspended or revoked.

(2) A proceeding for the issuance of an order under this subdivision may be included with a proceeding against a plan under this section or may constitute a separate proceeding, subject in either case to subdivision (d).

(d) A proceeding under this section shall be subject to appropriate notice to, and the opportunity for a hearing with regard to, the person affected in accordance with subdivision (a) of Section 1397.

SEC. 16. Section 1395.6 of the Health and Safety Code is amended to read:

1395.6. (a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in any payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed to the provider in advance and shall actively encourage patients to use the

network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

(1) Disclose to the provider whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.

(2) Disclose what specific practices, if any, payors utilize to actively encourage a payor's subscribers to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged its subscribers to use the list of contracted providers if one of the following occurs:

(A) The payor offers its subscribers direct financial incentives to use the list of contracted providers when obtaining medical care. ''Financial incentives'' means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information to subscribers advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to subscribers in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet web site addresses supplied directly to every subscriber. However, Internet web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in

this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a subscriber.

(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the payors' subscribers to use the list of contracted providers when obtaining medical care.

(4) Disclose, upon the initial signing of a contract, and within 30 calendar days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreement with any contracting agent.

Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's subscribers to use the list of contracted providers when obtaining medical care in the case of an emergency.

(c) A contracting agent shall allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' subscribers to use the list of contracted providers when obtaining medical care as described in paragraph (2) of subdivision (b). Each provider's election under this subdivision shall be binding on every contracting agent or payor that buys, leases, or otherwise obtains a list of contracted providers.

(d) A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the payors' subscribers to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' subscribers to use the list of contracted providers when obtaining medical care.

(e) A payor shall provide an explanation of benefits or explanation of review that identifies the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

(f) A payor shall demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. The failure of a payor to do so shall render the payor liable for the amount that the payor would have been required to pay pursuant to the applicable health care service plan contract covering the enrollee, which amount shall be due and payable within 10 days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this subdivision. A payor shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:

(1) Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b).

(2) Identifies the provider's written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers sold, leased, transferred, or conveyed to payors that do not actively encourage beneficiaries to use the list of contracted providers pursuant to subdivision (c).

(g) For the purposes of this section, the following terms have the following meanings:

(1) ''Contracting agent'' means a health care service plan or a specialized health care service plan, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, conveying, or

arranging the availability of a provider or provider panel to provide health care services to subscribers.

(2) ''Payor'' means a health care service plan or a specialized health care service plan.

(3) ''Payor summary'' means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(4) ''Provider'' means any of the following:

(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200).

(E) Any entity exempt from licensure pursuant to Section 1206.

(h) This section shall become operative on July 1, 2000.

SEC. 17. Section 13933 of the Health and Safety Code is amended and renumbered to read:

1374.34. (a) Upon receiving the decision adopted by the director pursuant to Section 1374.33 that a disputed health care service is medically necessary, the plan shall promptly implement the decision. In the case of reimbursement for services already rendered, the plan shall reimburse the provider or enrollee, whichever applies, within five working days. In the case of services not yet rendered, the plan shall authorize the services within five working days of receipt of the written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

(b) A plan shall not engage in any conduct that has the effect of prolonging the independent review process. The engaging in that conduct or the failure of the plan to promptly implement the decision is a violation of this chapter and, in addition to any other fines, penalties, and other remedies available to the director under this chapter, the plan shall be subject to an administrative penalty of not less than five thousand dollars ($5,000) for each day that the decision is not implemented. Administrative penalties shall be deposited in the State Managed Care Fund.

(c) In any case where an enrollee secured urgent care or emergency services outside of the plan provider network, which services are later found by the independent medical review organization to have been medically necessary pursuant to Section 1374.33, the director shall require the plan to promptly reimburse the enrollee for any reasonable costs associated with those services when the director finds that the enrollee's decision to secure the services outside of the plan provider network prior to completing the plan grievance process or seeking an independent medical review was reasonable under the circumstances and the disputed health care services were a covered benefit under the terms and conditions of the health care service plan contract.

(d) In addition to requiring plan compliance regarding subdivisions (a), (b), and (c) the director shall review individual cases submitted for independent medical review to determine whether any enforcement actions, including penalties, may be appropriate. In particular, where substantial harm, as defined in Section 3428 of the Civil Code, to an enrollee has already occurred because of the decision of a plan, or one of its contracting providers, to delay, deny, or modify covered health care services that an independent medical review determines to be medically necessary pursuant to Section 1374.33, the director shall impose penalties.

(e) Pursuant to Section 1368.04, the director shall perform an annual audit of independent medical review

cases for the dual purposes of education and the opportunity to determine if any investigative or enforcement actions should be undertaken by the department, particularly if a plan repeatedly fails to act promptly and reasonably to resolve grievances associated with a delay, denial, or modification of medically necessary health care services when the obligation of the plan to provide those health care services to enrollees or subscribers is reasonably clear.

SEC. 18. Section 10123.135 of the Insurance Code, as amended by Chapter 539 of the Statutes of 1999, is amended to read:

10123.135. (a) Every disability insurer, or an entity with which it contracts for services that include utilization review or utilization management functions, that covers hospital, medical, or surgical expenses and that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A disability insurer that is subject to this section, or any entity with which an insurer contracts for services that include utilization review or utilization management functions, shall have written policies and procedures establishing the process by which the insurer prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for insureds. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to subdivision (f). These policies and procedures, and a description of the process by which an insurer, or an entity with which an

insurer contracts for services that include utilization review or utilization management functions, reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, shall be filed with the commissioner, and shall be disclosed by the insurer to insureds and providers upon request, and by the insurer to the public upon request.

(c) If the number of insureds covered under health benefit plans in this state that are issued by an insurer subject to this section constitute at least 50 percent of the number of insureds covered under health benefit plans issued nationwide by that insurer, the insurer shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or the Osteopathic Act, or the insurer may employ a clinical director licensed in California whose scope of practice under California law includes the right to independently perform all those services covered by the insurer. The medical director or clinical director shall ensure that the process by which the insurer reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, complies with the requirements of this section. Nothing in this subdivision shall be construed as restricting the existing authority of the Medical Board of California.

(d) If an insurer subject to this section, or individuals under contract to the insurer to review requests by providers, approve the provider's request pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an insured for reasons of medical necessity. The

decision of the physician or other health care provider shall be communicated to the provider and the insured pursuant to subdivision (h).

(f) (1) An insurer shall disclose, or provide for the disclosure, to the commissioner and to network providers, the process the insurer, its contracting provider groups, or any entity with which it contracts for services that include utilization review or utilization management functions, uses to authorize, delay, modify, or deny health care services under the benefits provided by the insurance contract, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. An insurer shall also disclose those processes to policyholders or persons designated by a policyholder, or to any other person or organization, upon request.

(2) The criteria or guidelines used by an insurer, or an entity with which an insurer contracts for utilization review or utilization management functions, to determine whether to authorize, modify, delays, or deny health care services, shall:

(A) Be developed with involvement from actively practicing health care providers.

(B) Be consistent with sound clinical principles and processes.

(C) Be evaluated, and updated if necessary, at least annually.

(D) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the policyholder in that specified case.

(E) Be available to the public upon request. An insurer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An insurer may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The insurer may also make the criteria or guidelines available through electronic communication means.

(3) The disclosure require by subparagraph (E) of paragraph (2) shall be accompanied by the following notice: ‘‘The materials provided to you are guidelines used by this insurer to authorize, modify, or deny health care benefits for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your insurance contract.

(g) If an insurer subject to this section requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the insurer shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, based in whole or in part on medical necessity, every insurer subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with, the provision of health care services to insureds that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the insured’s condition, not to exceed five business days from the insurer’s receipt of the information reasonably necessary and requested by the insurer to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual’s designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the insured’s condition is such that the insured faces an imminent and serious threat to his or her

health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the insured's life or health or could jeopardize the insured's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to insureds shall be made in a timely fashion, appropriate for the nature of the insured's condition, but not to exceed 72 hours after the insurer's receipt of the information reasonably necessary and requested by the insurer to make the determination.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to insureds shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the insured's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the insured in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the insured's treating provider has been notified of the insurer's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds shall be communicated to insureds in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall

include a clear and concise explanation of the reasons for the insurer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification or a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the provider or the insured may file an appeal with the insurer or seek department review under the unfair practices provisions of Article 6.5 (commencing with Section 790) of Chapter 1 of Part 7 of Division 1 and the regulations adopted thereunder.

(5) If the insurer cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the insurer is not in receipt of all of the information reasonably necessary and requested, or because the insurer requires consultation by an expert reviewer, or because the insurer has asked that an additional examination or test be performed upon the insured, provided that the examination or test is reasonable and consistent with good medical practice, the insurer shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2), or as soon as the insurer becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the insured, in writing, that the insurer cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The insurer shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information

reasonably necessary and requested by the insurer, the insurer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the commissioner determines that an insurer has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the commissioner may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed an exclusive remedy for the commissioner. These penalties shall be paid to the Insurance Fund.

(i) Every insurer subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) Nothing in this section shall cause a disability insurer to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 19. Section 10145.3 of the Insurance Code is amended to read:

10145.3. (a) Every disability insurer that covers hospital, medical, or surgical benefits shall provide an external, independent review process to examine the insurer's coverage decisions regarding experimental or investigational therapies for individual insureds who meet all of the following criteria:

(1) (A) The insured has a life-threatening or seriously debilitating condition.

(B) For purposes of this section, ''life-threatening'' means either or both of the following:

(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(C) For purposes of this section, ‘‘seriously debilitating’’ means diseases or conditions that cause major irreversible morbidity.

(2) The insured’s physician certifies that the insured has a condition, as defined in paragraph (1), for which standard therapies have not been effective in improving the condition of the insured, for which standard therapies would not be medically appropriate for the insured, or for which there is no more beneficial standard therapy covered by the insurer than the therapy proposed pursuant to paragraph (3).

(3) Either (A) the insured’s contracting physician has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to the insured than any available standard therapies, or (B) the insured, or the insured’s physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the insured’s condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in subdivision (d), is likely to be more beneficial for the insured than any available standard therapy. The physician certification pursuant to this subdivision shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require the insurer to pay for the services of a noncontracting physician, provided pursuant to this subdivision, that are not otherwise covered pursuant to the contract.

(4) The insured has been denied coverage by the insurer for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph (3), unless coverage for the specific therapy has been excluded by the insurer’s contract.

(5) The specific drug, device, procedure, or other therapy recommended pursuant to paragraph (3) would

be a covered service except for the insurer's determination that the therapy is experimental or under investigation.

(b) The insurer's decision to deny, delay, or modify experimental or investigational therapies shall be subject to the independent medical review process established under Article 3.5 (commencing with Section 10169) of Chapter 1 of Part 2 of Division 2, except that in lieu of the information specified in subdivision (b) of Section 10169.3, an independent medical reviewer shall base his or her determination on relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence defined in subdivision (d).

(c) The independent medical review process shall also meet the following criteria:

(1) The insurer shall notify eligible insureds in writing of the opportunity to request the external independent review within five business days of the decision to deny coverage.

(2) If the insured's physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall be rendered within seven days of the request for expedited review. At the request of the expert, the deadline shall be extended by up to three days for a delay in providing the documents required. The timeframes specified in this paragraph shall be in addition to any otherwise applicable timeframes contained in subdivision (c) of Section 10169.3.

(3) Each expert's analysis and recommendation shall be in written form and state the reasons the requested therapy is or is not likely to be more beneficial for the insured than any available standard therapy, and the reasons that the expert recommends that the therapy should or should not be covered by the insurer, citing the insured's specific medical condition, the relevant documents, and the relevant medical and scientific evidence, including, but not limited to, the medical and

scientific evidence as defined in subdivision (d), to support the expert's recommendation.

(4) Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to other benefits under the contract.

(d) For the purposes of subdivision (b), ''medical and scientific evidence'' means the following sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(2) Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS data base Health Services Technology Assessment Research (HSTAR).

(3) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.

(4) The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information.

(5) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the

purpose of evaluating the medical value of health services.

(6) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

(e) The independent review process established by this section shall be required on and after January 1, 2001.

SEC. 20. Section 25002 of the Welfare and Institutions Code is amended to read:

25002. To develop the options for achieving universal health care coverage described in Section 25001, the secretary shall establish a process by which these options are developed. The process shall at a minimum include the following:

(a) The examination and utilization of research results from the study performed by the University of California with regard to methods of financing, delivering and defining universal health care coverage, done pursuant to the criteria in Senate Concurrent Resolution 100 of the 1997–1998 Regular Session of the Legislature.

(b) The examination and utilization of other data and information, as requested by the secretary or provided to the secretary, with regard to methods of financing, delivering, or defining universal health care coverage.

(c) Developing a process by which representatives of health care consumers, providers, insurers, health care workers, advocates, counties, and all other interested parties are engaged in discussion and debate of the issues faced by the state in providing universal health coverage. The secretary shall develop the methods by which this discussion occurs, provided that it is broadly inclusive of all groups with an interest in universal health care coverage.

(d) Interagency participation including, but not limited to, the State Department of Health Services, the State Department of Mental Health, the Department of Finance, the Managed Risk Medical Insurance Board, the Department of Consumer Affairs, the Public Employees' Retirement System, the State Department of Social Services, the Department of Managed Health Care, the Department of Insurance, and any other appropriate

agencies which the secretary determines can contribute to the effort to provide universal health care coverage.

(e) Obtaining information from the United States Health Care Financing Administration regarding federal waivers or other forms of federal participation, if necessary.

SEC. 21. (a) Section 2.1 of this bill incorporates amendments to Section 56.10 of the Civil Code proposed by both this bill and AB 2414. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2001, (2) each bill amends Section 56.10 of the Civil Code, and (3) SB 1903 is not enacted or as enacted does not amend that section, and (4) this bill is enacted after AB 2414, in which case Sections 2, 2.2, and 2.3 of this bill shall not become operative.

(b) Section 2.2 of this bill incorporates amendments to Section 56.10 of the Civil Code proposed by both this bill and SB 1903. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2001, (2) each bill amends Section 56.10 of the Civil Code, (3) AB 2414 is not enacted or as enacted does not amend that section, and (4) this bill is enacted after SB 1903 in which case Sections 2, 2.1, and 2.3 of this bill shall not become operative.

(c) Section 2.3 of this bill incorporates amendments to Section 56.10 of the Civil Code proposed by this bill, AB 2414, and SB 1903. It shall only become operative if (1) all three bills are enacted and become effective on or before January 1, 2001, (2) all three bills amend Section 56.10 of the Civil Code, and (3) this bill is enacted after AB 2414 and SB 1903, in which case Sections 2, 2.1, and 2.2 of this bill shall not become operative.

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